

## Administrative

## MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SAMIR LUITEL LAXMI PRASAD LUITEL  
Card No : I040-029-118669825-01  
Policy Holder : SAMIR LUITEL LAXMI PRASAD LUITEL

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 02-01-2025 To 01-01-2026

Gender : Male

Date Of Birth : 27-Feb-2000

Patient's Tel No : 971528161096

Service Date :04-Feb-2025

Network : Green

Health Provider :CITICARE MEDICAL CENTER LLC

Direct Access SP - YES

Doctor's Name :SANDIA

Co-Insurance:

|              |               |        |           |     |           |        |
|--------------|---------------|--------|-----------|-----|-----------|--------|
| CONSULTATION | LAB/RADIOLOGY | PHYSIO | PHARMACY  | IP  | MATERNITY | DENTAL |
| 10% max      | NIL           | NIL    | NIL LIMIT | NIL | 10%       | NA     |

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : pc: severe sore throat and itiness since 1 week cough sore throat bothers sleep in the night. cant not drink water even because of pain in throat no fever oe: throat is hyperemic clear chest

Vitals:Temp : 36 Bp :135 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R05 - Cough,J00 - Acute nasopharyngitis [common cold], Date of Onset :04/05/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP

Estimated :  
Cost

Prescriptions: 5314-274301-0392 - (LEVOFLOXACIN (AS HEMIHYDRATE : 500 MG FILM COATED TABLETS,0005-114501-2481 - (AMBROXOL : 15 MG/5ML SYRUP (SUGAR FREE,0195-123701-0391 - (CETIRIZINE HCL : 10 MG FILM COATED TABLETS,

Estimated :  
Cost

## MEDICAL PRACTITIONER DECLARATION :

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

## PATIENT'S DECLARATION :

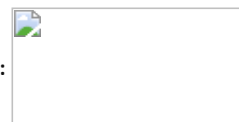
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : SANDIA

Stamp :



Patient's signature{Parent : if minor}



Date : Feb-2025

Signature :

Date : 04-Feb-2025